

Vanguard MedReview, Inc.

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Notice of Independent Review Decision

February 10, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Laminotomy and Discectomy L5 right side

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This reviewer is a Board Certified Orthopedic Surgeon with over 13 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx lifting. He was seen at a local urgent care center, then and referred for Physical Therapy.

07/30/2013: Office Note. **HPI:** Patient presents with lower back pain after lifting a dump truck tire. **Subjective:** Patient's chief complaint is of LBP with left bilateral LE burning and numbness. The symptoms are with prolonged. Functional Limitations: Prolonged sitting, ambulation long distance, and bending forward. Relieving factors: rest Special Tests: MRI: degenerative disc disease levels L4-L5 and L5-S1. **Objective:** Posture: Patient was observed in a standing position today. Hips are in alignment at this time. Standing posture exhibits a mild forward head, mild protraction of the shoulders and no winging of the scapula noted. He exhibits a mild decrease in LB lordosis. Palpation: The patient presents with tenderness in the following areas: LB PVM, along the iliac crest, Along the SP of L1-5, and at the piriformis muscles. Gait: Patient has some difficulty with the ambulation including stairs due to continued pain and weakness. **Assessment:**

This patient presents with signs and symptoms consistent with the diagnosis given by the physician. Generally, the patient has some limitations in ROM, tightness of the trunk and LE musculature and limited function. Problem: Lumbar decreased LB AROM, persistent pain in the LB region limiting function and spasms and tenderness in the LB musculature. **Plan:** Therapy 3 times per week for two weeks.

12/10/2013: Treatment Note. **Procedure:** Left L4-L5 Transforaminal Epidural Steroid Injection (L4 Nerve Root) Right L5-S1 Transforaminal Epidural Steroid Injection (L5 Nerve Root) and Left L5-S1 Transforaminal Epidural Steroid Injection (L5 Nerve Root) under Fluoroscopic Guidance. **Post-OP Diagnosis:** Chronic low back pain radiating down right leg, low back pain radiating down left leg, chronic lumbago, right L5 radicular pain, Left L4 radicular pain, left L5 radicular pain, herniated disc with root compression at L4-L5, herniated disc with root compression at L5-S1. **Findings:** Radiology: A scout film was performed. This showed no bony abnormalities L5-S1. An epidurogram was performed. The left L4, right L5 and left L5 epidurogram showed excellent spread to L4-5 and L5-S1. There was obstruction within the lateral recess and obstruction at the foramen with dorsal anterior, inferior and superior displacement of contrast. The epidurogram showed excellent outlining of the exiting root disc space.

01/27/2014: History and Physical. **HPI:** The patient states the lumbar spine pain is limiting, severe and limits activities of daily living. He states the pain wakes him up at night. He states he has tried the following medications: cyclobenzaprine Oral tablet 10 mg, gabapentin oral capsule 300 mg, meloxicam oral tablet 15 mg, naproxen oral tablet 500 mg, prednisone oral tablet 20 mg, and skelaxin oral tablet 800 mg. He states he has not had relief with PT. He is currently working at limited duty. **Physical Exam:** Moderate reduced ROM, moderate pain on ROM. Muscle strength: EHL is 5/5 on the right and 4/5 on the left, tibialis anterior is 5/5 on the right and 4/5 on the left. Peroneal musculature is 5/5 on the right and bilaterally equal. Quadriceps are 5/5 and bilaterally equal. Hamstrings are 5/5 on the right and 4/5 on the left. Faber test positive on the left. Sensation is decreased to light touch of lateral aspect of the left foot. Deep tendon reflexes are 1/4 in the patellar and Achilles jerks and are bilaterally equal. Normal gait. Results: Review of the CT images reveals what appears to be a left sided disc herniation at the L5 level. This cannot be clearly seen on the CT scan. There is no sign of a fracture or dislocation noted. **Assessment:** Lumbago, Lumbar Radiculitis **Plan:** MRI-Lumbar Spine without contrast, FOV in 6 weeks.

05/15/2014: MRI lumbar spine without IV contrast. **Impression:** 1. L2-L3 through L5-S1 disc herniations. 2. L4-L5 and L5-S1 moderate bilateral, L2-L3 mild to moderate right and mild left, and L3-L4 mild to moderate left and mild right neural foraminal narrowing.

06/16/2014: Progress Note. **HPI:** Patient complains of lower back pain with radiation to the left lower extremity and describes it as sharp. He has been previously treated with PT and NSAIDs. The PT was effective in relieving pain. The NSAIDs was partially effective in relieving pain. He is working with 20# weight

restriction. He says pain is 8/10. He had dog bites to his right leg and arm in April. **Physical Exam:** Straight leg raise test negative bilaterally today. Right lower extremity neurologically decreased lateral thigh. Patellar tendon reflex trace, ankle reflex absent Vascular Exam: dorsalis pedis artery pulse 2+, posterior tibial artery pulse 2+, capillary refill normal left lower extremity Gait: Normal, able to stand without difficulty **Assessment:** Chronic pain syndrome, displacement of Lumbar Intervertebral Disc without Myelopathy, Lumbago **Plan:** Apparently FCE and MRI and ESI's were all denied payment. He is now going to seek treatment elsewhere.

09/17/2014: Office Note. **HPI:** Patient continues to have severe pain and discomfort in his back and right lower extremity. The pain radiates to his right buttock, right hip and into the right lower extremities pass the level of the knee. His MRI dated 5/15/14 reveals disc degeneration through the lumbar spine. I do not believe this was related to his work injury, however, the patient does have a disc herniation at the L5 level on the right side that directly about and causes pressure on the exiting S1 nerve root. This is exactly consistent with the patient's pain and discomfort. Mr. Cano has had PT in the past as well as epidural steroid injection. He failed to respond to either form of treatment. I believe Mr. Cano's pain is associated with the disc herniation at L5 level on the right side. I believe his best option at this time would be surgical intervention for lumbar laminotomy and discectomy at the L5 level on the right.

11/12/2014: UR. **Rationale for Denial:** ODG for a discectomy and laminectomy are not met. In this case, the patient is overweight and does not have any neurologic deficits. The MRI reveals changes at multiple levels but does not rule out the possibility of a significant nerve compression. Also, most of the pains recorded in the notes suggest that the patient's pain is in the back and legs. Therefore, the requested lumbar laminotomy and discectomy L5 on right is not medically necessary and appropriate.

12/10/2014: Office Visit. **HPI:** Patient presents with constantly occurring symptoms. He continues to take hydrocodone to help decrease the pain. states that his pain is not improving. The pain is actually becoming worse as time goes on. He continues to have pain and discomfort in his left lower extremity with numbness in that same extremity. He also has some discomfort in his right lower extremity. **Physical Exam:** Posture is stooped forward, Ht: 5'6" Wt: 256 lbs, Comments: The MRI of the lumbar spine from May 2014 was again reviewed. The MRI shows a large bulging disc at the L5 level. It appears that there is a more prominent right paracentral bulge than left, however, on closer review of the MRI of the left sided disc is bulging contacting the exiting nerve root. Lumbar Spine ROM: Restriction, flexion severe restriction, extension severe restriction, lateral bending severe restriction. Neurovascular LE: Reflexes-Patella: Right ¼, left ¼ Achilles: Rt: 0/4, Left 0/4, Vascular-Dorsalis pedis: Rt normal, left: normal. Strength Measurement-knee flexion: Right: 5/5, left: 5/5. Knee extension: Right 5/5 Left: 5/5. Ankle long peroneal: Rt: 4/5, Left: 4/5. Ankle Dorsiflexion. Right 4/5, Left 4/5. Foot Extensor hallucis longus: Right 4/5, left 4/5. **Assessment:** Low Back Pain **Impression:** I believe that the bulging L5 disc is causing pressure on both exiting L5 and S1 nerve roots. This explains the weakness noted on physical

exam today as well as the sciatic tension sign on straight leg raising. I believe that the bulge is a result of the patient's workers compensation injury. He has tried and failed an adequate course of conservative therapy. He was given treatment options available to him and is elected to proceed with surgical intervention for a lumbar laminotomy and discectomy at the L5 level. Based on his height and weight and body mass index I do not believe that a fusion is necessary or recommended. I think that a lumbar laminotomy and discectomy from the right side possibly extending to the left side would be appropriate treatment for his current condition.

01/12/2015: UR. **Rationale for Denial:** ODG indications for discectomy and laminectomy require symptoms and findings which confirm the presence of radiculopathy. In this case, the patient has multiple levels of disc abnormality with disc bulges but the objective neurological exam was normal as per the October 2014 physical exam. There were no electro diagnostic studies to help validate the presence of a correlated abnormality of the L5 or S1 nerve roots. The records also noted that the epidural steroid injection done in December 2013 did not benefit the patient. The patient does not appear to have an objective radiculopathy that would warrant the proposed surgery at L5 on the right. Therefore, the request for lumbar laminotomy and discectomy L5 right side is not medically necessary or appropriate.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse determinations are upheld. The patient presents with pain in the lower back and both legs. He has completed epidural injections in December 2013. The May 2014 MRI demonstrates multiple levels of disc herniation. The December 2014 office note documents bilateral lower extremity weakness and hypo-reflexia. Based on the records reviewed, it is unclear which disc level is the source of the patient's radicular symptoms. There is no documentation of any improvement in his symptoms following the epidural injections of 2013. The appropriate level of nerve compression should be confirmed by EMG-NC study prior to consideration of surgery. A fusion may be required, in addition to the decompression, to address the patient's back pain. For these reasons, Lumbar Laminotomy and Discectomy L5 right side is not medically necessary at this time and should be denied.

Per ODG:

Recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery (standard posterior decompressive laminectomy alone, without discectomy) offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement that was maintained at 2 years of follow-up, according to a new SPORT study. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamentary hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc. ([Weinstein, 2008](#)) ([Katz, 2008](#)) This study showed that surgery for spinal stenosis and for disc herniation were not as successful as total hip replacement but were

comparable to total knee replacement in their success. Pain was reduced to within 60% of normal levels, function improved to 65% normal, and quality of life was improved by about 50%. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. ([Hansson, 2008](#)) A comparison of surgical and nonoperative outcomes between degenerative spondylolisthesis and spinal stenosis patients from the SPORT trial found that fusion was most appropriate for spondylolisthesis, with or without listhesis, and decompressive laminectomy alone most appropriate for spinal stenosis. ([Pearson, 2010](#)) In patients with spinal stenosis, those treated surgically with standard posterior decompressive laminectomy showed significantly greater improvement in pain, function, satisfaction, and self-rated progress over 4 years compared to patients treated nonoperatively, and the results in both groups were stable between 2 and 4 years. ([Weinstein, 2010](#)) Comparative effectiveness evidence from SPORT shows good value for standard posterior laminectomy after an imaging-confirmed diagnosis of spinal stenosis [as recommended in ODG], compared with nonoperative care over 4 years. ([Tosteson, 2011](#)) Decompressive surgery (laminectomy) is more effective for lumbar spinal stenosis than land based exercise, but given the risks of surgery, a self-management program with exercise prior to consideration of surgery is also supported. ([Jarrett, 2012](#)) This study indicates that in patients with a primary diagnosis of lumbar spinal stenosis (LSS), the rate of fusions and the use of implants has increased, and the decompression rate has decreased. Trends in the surgical management of stenosis have become increasingly important to study because more invasive procedures, including the addition of fusion and the use of implants, have been associated with greater use of resources and increased complications. ([Bae, 2013](#)) Laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The lamina of the vertebra is removed or trimmed to widen the spinal canal and create more space for the spinal nerves. See also [Discectomy/laminectomy](#) for surgical indications, with the exception of confirming the presence of radiculopathy. For average hospital LOS after criteria are met, see [Hospital length of stay](#) (LOS).

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR
OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL &
ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY
GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR
GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW
BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN
ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE &
PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**